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Late-Life Emergence of Early-Life Trauma

The Phenomenon of Late-Onset Stress Symptomatology Among Aging Combat Veterans

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This study aimed to provide preliminary evidence for, and explore potential antecedents and correlates of, a phenomenon observed in aging combat veterans termed *late-onset stress symptomatology* (LOSS). LOSS is a hypothesized phenomenon among older veterans who (a) experienced highly stressful combat events in early adulthood; (b) functioned successfully throughout their lives, with no chronic stress-related disorders; but (c) begin to register increased combat-related thoughts, feelings, reminiscences, memories, or symptoms commensurate with the changes and challenges of aging, sometimes decades after their combat experiences. Using a qualitative focus group methodology with 47 World War II, Korean Conflict, and Vietnam War veterans, the authors obtained preliminary evidence for the presence of LOSS as defined, identified some of its features, revealed some normative late-life stressors that may precipitate LOSS, and uncovered potential intrapersonal risk and resilience factors for LOSS. The authors present illustrative quotations from the group discussions and discuss the implications and future directions of this research.

Keywords: *aging; combat veterans; combat trauma; life-course effects of trauma; focus group research*

> Maybe I have more time on my hands or maybe as we get older—when we're young and we're 40 or 50 you're not thinking of older years or death or illness.
>
> As we now reach a certain point in our lives, certain things come to mind. . . . We seem to reflect more.
>
> At our age, there should be some type of therapy for us. We remember more about the war now than ever. We are older and have more time to reflect.
>
> —World War II veterans

In recent years, both gerontological researchers and clinicians have begun to note and document combat-related problems in the older adult veteran

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population. There is already an abundance of research, much of it conducted with Vietnam veterans, concerning the effects of combat exposure on veterans recently returned from the war zone (e.g., Boscarino 1979; Egendorf et al. 1981; Thienes-Hontos, Watson, and Kucala 1982). Much research has also been conducted with those veterans who are chronic sufferers of posttraumatic stress disorder (PTSD; e.g., Bollinger et al. 2000; King et al. 1999; Kulka et al. 1990; McFall et al. 1999). Additionally, long-term effects of trauma, delayed manifestations of trauma, intermittent trauma-related symptoms, and late-life exacerbation of trauma-related symptoms have now been documented in the aging combat veteran population (e.g., Buffum and Wolfe 1995; Falk, Hersen, and Van-Hasselt 1994; Hunt and Robbins 2001; Macleod 1994; Spiro, Schnurr, and Aldwin 1994; Zeiss and Dickman 1989). The present study sought to extend this line of inquiry to explore the possible connections between combat exposure in early adulthood and trauma-related reminiscences, memories, feelings, or symptoms occurring in the context of normative stressors, transitions, and losses in later life.

As the "baby boomers" in the United States enter older adulthood in increasing numbers, it is essential that practitioners working with older adults be equipped to identify potentially problematic trauma-related symptomatology in their patients and to treat it when appropriate. Moreover, a substantial proportion of older adults in the United States are veterans. Military service has been called the "hidden variable" in aging research (Spiro et al. 1994): In 1996, 76% of all men living in the United States aged 70 to 74 were military veterans (American Psychological Association Working Group on the Older Adult 1998). And by 2010, nearly 40% of this country's veteran population will be 65 years of age or older (VetPop2000 n.d.). This figure represents the veterans of World War II and Korea, as well as the approximately 3.4 million veterans who served in the Vietnam theater of operations. Given this older veteran population boom, it is crucial that we begin to systematically study, understand, and anticipate the psychological and physical health issues of this population.

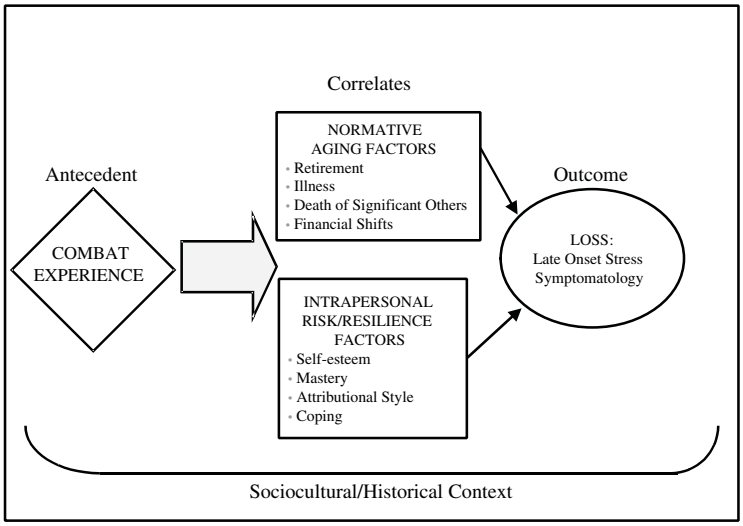
There has been a growing awareness of the phenomenon of war-related distress appearing in later life in both the professional mental health community and the popular media. Within the U.S. Department of Veterans Affairs (VA), clinical psychologists (including one of the authors, E.H.D.), psychiatrists, social workers, and other health providers have noted an increase in the number of older veterans seeking stress-related mental health treatment for the first time in their lives. In the lead article of the May 1998 American Psychological Association *Monitor* (Sleek 1998), VA clinical psychologists from around the country described cases in which veterans who had functioned well over many decades began to suffer stress symptomatology linked

to their prior wartime experiences as they entered their older years. Case studies also have appeared in the geriatric and psychiatric literatures reporting first-time stress reactions by World War II and Korean Conflict veterans as they reach old age, often occurring in the context of stressful yet normative late-life events. For example, Hyer and colleagues (1995) described a 72-year-old patient who, following the death of his wife, suddenly became "plagued with memories of fellow soldiers' deaths" (p. 531). Additional anecdotal evidence can be found in the popular media, which has reported "PTSD-like" reactions in previously high-functioning veterans attending the 50-year Normandy and Iwo Jima anniversary observances and "distressing reactions" among older veterans surrounding the 1998 release of the film *Saving Private Ryan* (Josephy 1999).

Observation of the recurring anecdotal and media evidence for late-onset stress, together with the growing attention being paid to late-life or delayed combat-related symptoms in the scientific literature, led to the postulation of a phenomenon our research group has termed late-onset stress symptomatology or LOSS. LOSS is a phenomenon among older veterans who (a) were exposed to highly stressful combat conditions in their early adult years; (b) have functioned successfully over the course of their lives, with no histories of chronic stress-related disorders; but (c) begin to register increased combat-related thoughts, feelings, reminiscences, memories, or symptoms commensurate with the changes of the aging process 30, 40, or even 50 years after their combat experiences. Symptoms may include intrusive memories of earlier combat events, sleep disturbances, and upset, and often appear following very stressful incidents in the veterans' lives, for example, the loss of a spouse or a physical illness. However, although some measure of distress and symptomatology may be seen in LOSS, this is not a prerequisite for the phenomenon; for some veterans, seemingly nondistressing increases in reminiscences, reflections, and memories may be the predominant feature of LOSS. Figure 1 presents a preliminary conceptual model of LOSS.

Many combat veterans have had difficult and distressing war experiences, and each veteran faces and deals with his or her stress differently. Some veterans exhibit postwar distress immediately following their wartime experiences. PTSD, as designated by the American Psychiatric Association (1994), is a condition observed in persons who have been exposed to highly stressful situations that evoke feelings of "intense fear, helplessness, or horror" (p. 428). People with PTSD may have flashbacks, nightmares, sleep difficulties, and very high startle responses, and they may go to great lengths to avoid reminders of the trauma. As seen in a significant number of Vietnam veterans, PTSD can develop immediately following a traumatic event. Yet many veterans who have come back from war zones after experiencing combat

Figure 1
Schematic Representation of Late-Onset Stress Symptomatology



have simply resumed their lives where they left off: They have married the women or men they left behind, quickly resumed their old jobs or started new ones, used the G.I. Bill to get back to or attend school, and appear to have left their war experiences behind them. These veterans may not have had observable difficulty dealing with the stress of war at the time, but for some, it may become more of an issue as they grow older.

A variety of studies have suggested that war-related trauma may render individuals vulnerable in old age (e.g., Lindemann 1944; Wortman and Silver 1989). Certainly, there is a body of literature on the health and functioning of military veterans in old age, most notably contributed by Elder and his associates (e.g., Elder and Clipp 1988, 1989; Elder, Shanahan, and Clipp 1994). A portion of this literature also focuses on combat-related PTSD (e.g., Aldwin, Levenson, and Spiro 1994; Fontana and Rosenheck 1994; Kahana, Harel, and Kahana 1989; Spiro et al. 1994). However, these studies do not fully capture the extent to which factors related to normative aging might elicit later life stress symptoms that may be linked to exposure to combat stressors in the distant past. That is, most elderly adults experience potentially stressful events such as retirement, the deaths of spouses and close friends, diminished physical capacity, and limited social support, but older

veterans may approach these events from a unique vantage point: that of one exposed to life-threatening combat stressors in their early years.

Why might earlier combat experiences become sources of upset for some aging veterans, many of whom appear to have heretofore functioned well? In their discussion of older survivors of childhood abuse, Gagnon and Hersen (2000) suggested that the activities of reminiscence and life review often observed in older adults may contribute to the delayed onset of trauma-related symptoms. This is consistent with the writings of Erikson (1968), who hypothesized that there exists a tendency or drive for people to engage in life review as they age, increasing the likelihood of these memories. Buffum and Wolfe (1995) postulated that common losses associated with the aging process—the loss of physical health, the loss of loved ones—and the concomitant feelings of powerlessness and helplessness may engender memories and feelings associated with combat-related trauma and loss. Others (e.g., Somer 2000) have hypothesized that the feelings of loss of control and autonomy that frequently accompany normative aging changes may serve to trigger memories or feelings of earlier trauma.

It also has been noted that there may be a connection between cognitive decline and dementia and the experience and expression of trauma symptomatology in old age (Floyd, Rice, and Black 2002; Grossman et al. 2004; McCartney and Severson 1997; "Traumatic Stress Disorder" 2000). Complicating this observed connection, however, is the fact that trauma symptoms in older adults can be mistaken for the beginnings of dementia. Case studies of older adults have noted that stress reactions to earlier trauma can include signs of confusion, concentration problems, memory loss, and functional impairment in older patients, all of which can clear once the trauma is addressed in treatment (Allers, Benjack, and Allers 1992). Moreover, older trauma survivors run the risk of being misdiagnosed with dementing processes, underscoring the potential for inappropriate medical and psychiatric treatment and the further loss of autonomy. Another factor that places older trauma survivors at potential risk for inappropriate medical treatment is the fact that older survivors often may express their distress through somatic rather than psychological symptoms (Somer 2000). In addition, even though there is little doubt that some elderly survivors' increased distress and trauma-related symptoms are triggered by cognitive decline and dysfunction, the importance of investigating the phenomenology of their distress and finding ways of easing it remains; in other words, regardless of etiology, it is of value to learn more about late-onset stress if it can potentially lead to greater understanding of the phenomenon and to the alleviation of suffering.

It is important to note that LOSS as we have conceptualized it should not be confused with what has previously been referred to as delayed-onset PTSD, because the latter has never been specifically associated with normative aging. The distinction between LOSS and delayed-onset PTSD is something that our research team has grappled with throughout this project, and the issue is discussed in greater detail in the concluding portion of this article. However, a few words here are merited to set the stage for the discussion of our focus group results. Clinically significant distress or functional impairment is a requirement for a diagnosis of PTSD but not of LOSS. Indeed, one potential way of conceptualizing LOSS is as an aspect of normative aging for some combat trauma survivors, and it is conceivable that many aging combat veterans who are experiencing late-onset stress related to earlier combat trauma do not interpret their "symptoms" as problematic or troublesome. Additionally, with PTSD, the life-threatening stressor—in psychiatric parlance, the "Criterion A event"—is the direct precipitant of PTSD, whereas we hypothesize that contextual and intrapersonal factors precipitate the development of LOSS. It is important to note that in our conceptual model of LOSS, combat exposure is not hypothesized to have a direct effect on the emergence of LOSS; rather, a history of combat exposure provides the personal historical context within which late-life stress can emerge. In other words, combat exposure is the necessary but not sufficient condition for the later development of LOSS, and the development of LOSS among combat-exposed older veterans is entirely filtered, as it were, through contextual and intrapersonal factors. Table 1 provides a comparison of PTSD and LOSS criteria; we return to the points outlined in this table in our concluding section.

Of course, not all aging veterans exhibit stress symptomatology, whether related to earlier war-zone events and circumstances or not. Hence, to the extent that there are individual differences in LOSS, there are likely intrapersonal risk and resilience factors that play a role. Specifically, in various veteran mental health research, contributing factors such as a veteran's appraisal of the value of the combat experience, coping style, and hardiness have been identified (e.g., Aldwin et al. 1994; Elder and Clipp 1988, 1989; King et al. 1998; Suvak et al. 1999a, 1999b). Within the field of gerontological research, certain beliefs and attributions have been shown to render aging individuals either more or less susceptible to mental health problems. Such variables include attributions of responsibility (Aldwin 1992), learned helplessness (Burns and Seligman 1991), perceptions of control (Ogden and Mitandabari 1997), mastery (Aldwin, Sutton, and Lachman 1996), and perceived self-efficacy (Bandura 1998). Therefore, in addition to normative stressors associated with the aging process, the conceptualization of LOSS

Table 1
Post-Traumatic Stress Disorder (PTSD) Versus Late-Onset Stress Symptomatology (LOSS): A Comparison

	PTSD	LOSS
Traumatic event	Direct precipitant (Criterion A event)	Necessary but not sufficient criterion
Reexperiencing symptoms	One or more required (Criterion B)	Not required
Avoidance symptoms	Three or more required (Criterion C)	Not required; rare
Hyperarousal symptoms	Two or more required (Criterion D)	Not required
Duration of disturbance	One month or longer (Criterion E)	Not applicable
Clinically significant distress or impairment in functioning	Required (Criterion F)	Not required
Onset	Anytime following traumatic event[a]	Later life by definition
Normative later-life events	Not applicable	Required context
Intrapersonal risk and resilience factors	Not mentioned in criteria	Required context
Reminiscence, life review	Not applicable	Major feature

a. The *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) recognizes that the onset of PTSD can be delayed and instructs clinicians giving diagnoses of PTSD to use the specifier "with delayed onset" if the disturbance begins six months or later following the traumatic event.

includes personal strengths and vulnerabilities that may contribute to the development of this phenomenon. Again, reference is made to the preliminary conceptual model of LOSS in Figure 1.

The purpose of the present study was to elicit preliminary evidence for the LOSS construct in terms of its phenomenology, antecedents, and correlates among a small sample of aging combat veterans. As described in more detail below, we adopted a qualitative, information-gathering approach because so little is known about this field of inquiry, and we were interested in hearing veterans' narratives as to whether they, or others they knew, had experiences related to the LOSS phenomenon. We also wanted to determine the extent to which the veterans believed that those experiences might be linked to stressors they had been encountering as they aged or to any other developmental or contextual factors related to the aging process. Moreover, we were particularly interested in disclosures of any risk or resilience factors that might have

rendered these veterans either more vulnerable or more impervious to late-life distress associated with early-life combat events and circumstances.

Method

Overview of Focus Group Methodology

This project applied qualitative focus group research methods. This information-gathering, qualitative approach was used to clarify the range of possible thoughts, feelings, memories, or symptoms being experienced; identify potential antecedents and triggering mechanisms (risk or vulnerability factors); identify possible coping strategies being used by our participants (resilience factors); and uncover contextual factors. Focus groups involve moderator-facilitated discussion among multiple participants. They are not clinical groups, and there is no treatment involved. Rather, participants in focus groups serve as expert informants and respond both to the moderator's questions and to the comments of other group members (Morgan 1996). Because focus group participants' comments can be elicited by what they hear from others in the group, the data are richer than if participants were simply responding to the moderator's questions, as they would in a one-on-one interview (Basch 1987; Gray-Vickrey 1993; Vogt, King, and King 2004). Additionally, research participants may be more candid in discussions with other members of their own cohort (in this case, other aging combat veterans) than they would be during one-on-one interviews with researchers who are not cohort members (Basch 1987; Vogt et al. 2004). Sensitive to the participants' frames of reference, the focus group moderator allows group members to guide discussion within a particular planned strategy of structured inquiry (Krueger 1998), using probe questions as needed.

Recruitment and Selection

Participants were recruited through the use of (a) flyers posted throughout the VA Boston Healthcare System, (b) contacts with local veterans groups such as the Veterans of Foreign Wars (VFW) and American Legion, and (c) a series of radio recruitment advertisements. Additionally, letters were sent to prospective volunteer veterans, followed by telephone contacts. Inclusion and exclusion criteria were addressed during brief telephone screenings. Most important, to participate in the focus groups, veterans had to have served in a combat zone during their military years. In keeping with the conceptualization of LOSS as a distinct phenomenon occurring within the con-

text of normative late-life events, not simply a continuation or exacerbation of earlier struggles, an attempt was made to exclude veterans with histories of psychiatric problems. Veterans were ruled ineligible for the focus groups if they answered affirmatively to either of the two following questions: "Have you ever seen, or are you currently seeing anyone for psychiatric problems?" and "Have you ever been hospitalized for psychiatric problems?"[1]

An attempt was also made to exclude those veterans whose cognitive status would make it difficult for them to participate in focus group discussions: If a veteran was able to understand the questions asked during the telephone screen and to respond appropriately, his cognitive functioning was judged to be acceptable for participation. At the end of the telephone screening, eligible veterans were informed that the study sought to "learn what your life has been like since you were in the war." They were informed that the focus groups would be audiotaped and would last approximately 90 minutes, and they were given appointments to participate in upcoming focus groups. Veterans were reminded of their scheduled focus group times by both letter and telephone and were asked to remember their glasses and hearing aids (if used).

Participants and Procedures

Forty-seven World War II ($n = 24$), Korean Conflict ($n = 18$), and Vietnam War ($n = 5$) veterans participated in the focus groups. Participants ranged in age from 54 to 89, with over half of the participants in their 70s. A majority (56%) were Army veterans, with substantial minorities having served in the Navy, the Marine Corps, and the Air Force or the Army Air Corps. Sixty-six percent were currently married. Our sample was a relatively educated group, with 36% having completed some college, 11% having graduated from college, and 19% having completed some graduate or professional school. The vast majority (94%) of participants described themselves as retired. Seven focus groups were conducted, with an average of approximately 7 individuals per group and a range of 3 to 10 members per group (except for one group of Vietnam veterans consisting of 2 members). For men, two groups were conducted for each war-era cohort; the seventh group was composed of 5 female military veterans (e.g., former members of the Women's Army Corps, Women Air Force Service Pilots, and Women Accepted for Volunteer Emergency Service from the Korean Conflict and World War II cohorts). See Table 2 for more details on focus group participants' characteristics.

Each focus group was conducted in a conference room at the Jamaica Plain Campus of the VA Boston Healthcare System. It is worth noting here that all focus groups for this study were held in January, February, and March

Table 2
Characteristics of Focus Group Participants (*n* = 47)

Variable	*n*	%
Age group (*n* = 47)		
50 to 59	5	10.6
60 to 69	10	21.3
70 to 79	25	53.2
80 to 89	7	14.9
Highest level of education (*n* = 47)		
No high school	1	2.1
Some high school	5	10.6
Completed high school	10	21.3
Vocational or technical training	0	0.0
Some college	17	36.2
Completed college	5	10.6
Graduate or professional work	9	19.1
Marital status (*n* = 47)		
Presently married	31	66.0
Presently not married	16	34.0
Retirement status (*n* = 47)		
Not retired	3	6.4
Retired	44	93.6
Length of retirement (*n* = 39)		
0 to 5 years	9	23.1
6 to 10 years	8	20.5
11 to 15 years	8	20.5
16 to 20 years	9	23.1
21 to 25 years	3	7.7
>25 years	2	5.1
Branch of service (*n* = 46)		
Army	26	56.5
Air Force or Army Air Corps	3	6.5
Navy	11	23.9
Marine Corps	6	13.0
Entrance into the military (*n* = 47)		
Drafted	12	25.5
Volunteered	35	74.5

2001, before the events of 9/11 and, consequently, before the United States went to war in Afghanistan and Iraq. The conference room was well lit, wheelchair accessible, and equipped with audiotaping equipment to record each session. Prior to the commencement of each focus group session, participants listened to a review of the consent form and signed it in the presence of a witness unrelated to the study. Participants completed a brief demographic

and health questionnaire that inquired about their eras and branches of military service, marital status, educational levels, retirement status, health and functional status, and the like. A clinical psychologist was on call during each session as a precaution. Each participating veteran received $50 as compensation for time and travel.

At the start of each focus group, participants were asked to introduce themselves, indicate where they had served in the military, and describe their military occupational specialties and primary military duties. The focus group moderator then led group members through a discussion designed to elicit experiences of homecoming, postwar education and careers, retirement and later life experiences, the types of coping strategies they used, and most important how they thought the process of aging had affected their physical and psychological health. The moderator introduced lines of discussion with open-ended questions such as "How would you describe your experience of retirement?" "What are your main concerns at this stage of your life?" "Have you experienced any dramatic changes in your life recently?" and "Have you encountered many medical problems recently?" She used more specific probe questions when needed to guide the discussion into the areas of interest to our research team: "Do you have concerns about family?" "Any deaths of family members? Friends?" "What kinds of medical problems have you encountered later in life?" and "How have you dealt with these problems?"

The last portion of the focus groups were designed to elicit discussion about whether the veterans ever thought about their wartime experiences now and what they made of these experiences at this stage in their lives. Open-ended questions such as "How often, if ever, do you think about your wartime experiences?" and " Looking back, how do you view your military experiences now?" were asked, with more specific probe questions if needed, such as "What kinds of things make you think about your wartime experiences?" and "Do you know of anyone who is troubled by his or her wartime experiences?" We found that often these questions were not needed, because focus group participants spontaneously mentioned their combat and wartime experiences in the context of speaking about late life. And, as discussed in the next section, veterans spontaneously linked increased reminiscences, reflections, and symptoms to factors associated with aging.

Analyses

The focus group data were analyzed at two levels: (a) audiotape review and (b) traditional qualitative research analysis.

The audiotapes were reviewed by members of the research team well acquainted with the LOSS conceptual model and with the themes that were

of most interest. Each audiotape was reviewed at least twice, once with instructions to merely listen and become globally familiar with the discussions and subsequently with instructions to transcribe passages of the discussions that pertained to LOSS and its potential antecedents and correlates.

For the traditional qualitative research analysis, the audiotapes were transcribed by a professional transcriptionist. Transcripts were then formatted and downloaded into NUD*IST 6. Transcripts were reviewed, themes were identified, and quotations were coded into themes. Some themes were further refined by creating subthemes to code subject matter into specific topics. In both approaches, the data analysis of focus group content was guided by the following specific research questions:

1. Have these veterans observed combat-related thoughts, feelings, memories, reminiscences, or symptoms (either in themselves or in friends or acquaintances) that resemble LOSS as proposed here?
2. From their own perspectives, how do they characterize the various features of the phenomenon?
3. Do their comments offer any suggestions as to why such a phenomenon might be occurring so many years after combat exposure?
4. Do the comments of these veterans suggest any particular background characteristics that might make one more vulnerable or more resilient?
5. Do the participants report normative events associated with aging, and do they independently link them to LOSS?
6. If they observe LOSS in themselves or others, does their commentary reveal attributions of responsibility, perceptions of control, self-efficacy, or strategies that seem to reduce symptoms?

At the completion of both data analyses, data were compared for consistency. Surprisingly, themes were quite similar; however, the NUD*IST analyses produced more data within each theme.

Results and Discussion

In this section, we address each of the six research questions concerning the LOSS phenomenon and provide elucidating quotes from the focus group discussions.

Research Question 1

Have these veterans observed combat-related thoughts, feelings, memories, reminiscences, or symptoms (either in themselves or in friends or acquaintances) that resemble LOSS as proposed here?

We believe that the data derived from the focus groups do indeed provide preliminary evidence for the existence of the LOSS phenomenon. As we defined the phenomenon, for symptoms, reminiscences, memories, or experiences to qualify as LOSS related, they must have onset in later life, and the combat veteran in question must have functioned relatively successfully over the course of his or her lifetime, with no reported history of chronic combat-trauma-related disorders. Our analysis of the data indicates that a good portion of the focus group participants acknowledged increased thoughts, feelings, memories, reminiscences, or symptoms, either in themselves or in others, that were emerging for the first time later in their lives. As the following representative comments from focus group members from different eras of military service illustrate, many combat veterans were aware of a change or a shift of sorts in their thoughts and feelings related to past wartime experiences, and some of them were puzzled as to why:

> I remember it [the war] more now and talk about it more now than I ever did before.
>
> All that stuff's [wartime memories] all coming back to me—why I don't know—the last couple of years, more and more's coming back.
>
> As the years go by, I think about it [the war] more and more.
>
> They say sometimes the posttraumatic stress is delayed—doesn't hit you right away, it comes up later on in life. [But] we're talking 29 years since I've come back from there.

Furthermore, as discussed in more depth below, some veterans noted that these thoughts, feelings, memories, reminiscences, or symptoms were emerging within the context of normative late-life changes and stressors.

Research Question 2

> From their own perspectives, how do they characterize the various features of the phenomenon?

An average of 85% of the veterans in each focus group reported increased thoughts and memories of their time in the war. Furthermore, although these thoughts and memories did not appear to be troublesome to some of our focus group participants, it was more common for our veterans to report that they were distressed by them and that they were taking a toll on their peace of mind, their mood, their sleep, or their ability to concentrate.

In three of the focus groups, veterans described having sudden, unwanted, and intrusive memories related to their wartime experiences. A few of these

veterans referred to these memories as "flashbacks." The veterans' spontaneous use of this term is intriguing and may be indicative of the extent to which posttraumatic stress terminology has permeated our popular culture. However, as they elaborated, it became clear that the veterans often were using the term more loosely than a mental health professional might. Although a couple veterans did indicate that they experienced brief moments during which they felt as though they were reliving traumatic combat events, most used the term *flashback* to describe a sudden disturbing memory with accompanying strong emotion. Although a few veterans did report that they had flashbacks since the time of their discharge from the military that they continued to experience from time to time today, approximately 50% of the veterans in these three focus groups mentioned experiencing flashbacks and other unpleasant memories and feelings for the first time during their later years, thus providing potential evidence for LOSS:

> Flashbacks now coming back from years ago . . . don't know what brings it on.
>
> I have a lot of flashbacks. They're not good ones.

Related to the experience of increased thoughts, memories, and flashbacks that veterans reported, they also described being reminded of their time in combat by everyday occurrences or activities:

> With me it's the American flag and other patriotic things.
>
> I watch the History Channel a lot [now], and that's what brings back memories—when you realize the folly . . . the stupidity and the coldness of some commanders who only think of themselves and basically to hell with the men. That's what brings back the war.

A female World War II veteran who worked in nursing commented,

> And one thing [that] reminds me is spears of peppermint . . . you remember putting that in the . . . well, when the bodies went back to the United States and they didn't have an embalming process, so they put spears of peppermint in these body bags. So, things like that remind me.

Although some of the veterans' comments suggested that their memories had always been brought on by everyday reminders and occurrences, others' remarks indicated that they were finding themselves more easily reminded of their wartime experiences than they used to be. In other words, even though reminders such as "the American flag and other patriotic things" had always

been present, many of our focus group participants found that these commonplace reminders had become more evocative for them in recent years:

> Maybe I have more time on my hands or maybe as we get older, when we're young and we're 40 or 50, you're not thinking of older years or death or illness. But as we now reach a certain point in our lives, certain things come to mind. I was looking at the *New York Times Book Review* and there's a book, *The Gentle Infantryman*, and all of a sudden I went and took it out of the library. I never would have done that before. We seem to reflect more.

Research Question 3

> Do their comments offer any suggestions as to why such a phenomenon might be occurring so many years after combat exposure?

Veterans in all our focus groups, across all three cohorts, advanced explanations as to why they might now be thinking more frequently about their traumatic combat experiences and, in some cases, feeling increased distress related to these thoughts. One prominent theme that emerged was the role of a recent increase in reminiscence. Consistent with developmental theory discussed earlier (e.g., Erikson 1968), numerous comments during the focus groups indicated that many of the veterans found themselves reminiscing and reviewing significant periods in their lives more now than they had when they were younger:

> The years are going by and we know it and reflect more. That's what it really is. We reflect.
>
> We think about the war more now because we're getting old—we're at the end of our lives.
>
> And as I see my grandchildren—I think age has to do with it. We reflect. I mean, old soldiers never die; they try not to. But they fade away. You do reflect more than ever.

Another veteran, in the process of expressing his distress at his recent-onset symptoms, stated,

> At our age, there should be some type of therapy for us. We remember more about the war now than ever. We are older and have more time to reflect.

Most veterans were clear that their time in the service—whether it was positive, negative, or, in the case of most veterans, a mixture of both—was

extremely formative, and, tied to an observed increase in reminiscence, many were actively struggling to figure out why, as these veterans articulated:

> I know being in the service had an effect, but I don't know how.

> But now little things trigger thoughts—because we're seniors, we have more time, we're getting older and we have the memories of that time. For us who were probably, as you said, under 20, it was the most momentous time of our life.

As presented in the previous quotations, a theme that emerged time and again in the group discussions was the fact that these veterans simply found themselves with more time to reflect later in life. However, in some instances, it was because certain significant roles—father, husband, wage earner—had shifted or disappeared. As one veteran observed,

> When you're away from the war and you're getting married and children and work and school and whatever, you somehow leave it behind . . . but as we get older, we seem to remember it more.

Another veteran, who was experiencing some troubling recollections and anxiety related to his wartime memories, commented,

> Once I got back here, I saw my mother and my father and I went to New York and I was so busy—parties eight nights a week down there—I didn't have an adjustment . . . I didn't have an adjustment until years later . . . thinking about . . . you think back.

More specifically, a majority of the focus group participants indicated that following retirement, they found that they had more time to think about the past; the role of retirement is discussed in greater detail in a following section, but suffice it to say that several focus group members indicated that with this newfound postretirement free time, they had discovered themselves actively seeking out opportunities to reflect on their wartime experiences. One World War II veteran stated,

> Five or 10 years ago, after I retired, I [started to] read a lot of military history, so I'm always coming across things that prompt me to think about something else.

Another World War II veteran described visiting Normandy, now that he found himself with the free time and the inclination to do so:

> I broke down and I was crying; I was on my knees crying on the grave there. It was the first time I was really able to. I probably couldn't have done it years ago. But as we get older, I find through a lot of friends who were veterans in combat, we remember more at this part of our life than we ever did before.

Research Question 4

> Do the comments of these veterans suggest any particular background characteristics that might make one more vulnerable or more resilient?

Our research group found this question more difficult to answer than the other questions. We searched the focus group data for background characteristics or predispositions that might render certain combat veterans more vulnerable to LOSS than others, but because of the direction the focus group discussions generally took, it was difficult to uncover these characteristics. One possibility suggested by the comments of focus group participants is that those veterans who tended to "block out" thoughts and memories over the course of their lives might be more vulnerable to particularly intense, unwanted, or intrusive memories of combat and wartime experience later in life. One veteran who reported a recent onset of disturbing war memories expressed the following:

> I got home, it was wonderful. And I think I blocked the war out. I really did, I blocked it out. I just wanted to have a good time, be home with my four sisters, my parents, friends. And I actually really blocked it out completely. It came back later, but I did block it out [earlier].

On a related note, a discussion of lifetime alcohol use and its function in blocking out unpleasant memories took place in almost all of our focus groups. We surmised from the veterans' observations that veterans who had used this coping strategy across the courses of their lifetimes might be particularly susceptible to LOSS-related problems later in life. For example, one World War II veteran who had stopped drinking later in life and who was now experiencing combat-trauma-related distress reported,

> I never took a drink in my life when I was a kid, but at 18 I started drinking in France. And it killed a lot of memories. Like I said, for the next 25 years, I kept drinking. But other people have been through a lot of things and you never hear them mention it for the simple reason it would probably bother them to mention it, so they just blank it out. And the best way is with booze.

A Vietnam veteran who noted an increase in memories and dreams about his time in the military commented,

> I've found that in the last four years, since I've been sober, I dream about [the war]—not constantly, but once in a while . . . but when I was drinking, I never did.

Veterans spoke of the value of having obtained an education and described taking advantage of the G.I. Bill on their return to the United States. It was clear that those who had obtained educations felt more satisfied with the trajectories of their postmilitary careers. For example, in one World War II focus group, the following dialogue ensued between the moderator and the veterans:

Moderator: How many of you went back to school after the war? [Counting hands] One, two, three, four, five, six, seven.
Veteran 1: Almost all.
Moderator: Who used the G.I. Bill to go back to school?
Veteran 2: We had to. When I graduated high school, I had nothing, so I had to go back to school. Afterwards in '43, I didn't know what I'd be doing. The jobs weren't that great either at the time, I felt, enough to start my education. So I decided I could do anything and as a result I had a good career.

Research Question 5

> Do the participants report normative events associated with aging, and do they independently link them to LOSS?

Veterans in the seven focus groups described normative late-life events such as retirement, physical illness, the death of a spouse or other significant person, and the aging process in general, and they spontaneously linked their normative late-life events to their war memories. It appeared that LOSS phenomena had emerged during or shortly after life changes or stressors normative to the aging process. For example, one World War II veteran who had lost his wife within the past few years clearly articulated that his war-related distress had worsened significantly during the period of time following her death. Another veteran appeared to express a view to which other veterans in his group related:

Veteran: As a prisoner of war, there were a lot of deaths, and a lot of deaths that we saw happen were just at the beginning of being prisoners. We felt that a lot of them just mentally [gave up] because they figured they had no hope. It's the

> same thing that I experience now as an older person. You lose hope and you lose the will to live. And if you lose the will to live, then you're a dead duck.
> *Veterans:* [Concurrence]: That's it.

Some veterans who reported potential LOSS-related symptoms explicitly drew a connection between increasing health problems and the tendency to recall earlier combat experiences. One veteran, recalling the pain and fear of combat and noting that his combat-sustained injury was causing him more difficulty in recent years, observed the following:

> Whenever I have any trouble with my knee, I can remember helping carry a guy out of a minefield . . . who had his leg blown off above the knee, and I remember I was on the foot of the stretcher taking him out.

A World War II veteran explained what he went through after having a heart attack in recent years:

> Everybody's different. I didn't want that [to be debilitated]. I felt I was in combat. I hate to say it, but I really did. And I said, "Terry [his wife], I'm going to beat this." I'm overweight, but I went on an extensive exercise program.

As mentioned earlier, retirement appeared to have an effect on the lives of the combat veterans who considered themselves to be retired, and although many expressed quite positive views of retirement, some indicated that the process of retirement had been challenging for them in some ways. The common view about why it was important to continue some kind of work was expressed by a Korean Conflict veteran:

> Don't retire . . . because when you work, I've been working all my life, and you're very active. We need people. You go to work, you have coffee breaks, you have conversation pieces like we're having today here and everyone shares. It makes you feel better.

A World War II veteran stated,

> People think that when I'm 65, fine, you go into retirement. And when I hit 65, the first six months of retirement were fine. But that was it . . . I went back to work and I've been working ever since.

Consistent with the literature (e.g., Bosse et al. 1992; Bosse, Spiro, and Kressin 1996; Bosse, Spiro, and Levenson 1997; Kim and Moen 2001),

although retirement is a positive or a neutral event for most older adults, it can be a stressful life event for some. In particular, older veterans with stress disorder can experience an exacerbation of symptoms following retirement, particularly when they retire for health-related reasons (Kaup, Ruskin, and Nyman 1994; Zeiss and Dickman 1989). Additionally, a recent study (Schnurr et al. 2005) found that veterans with current PTSD or histories of PTSD experienced greater increases in both psychological and physical symptoms than veterans with no PTSD histories. We found that retirement sometimes appeared linked to features of late-onset stress, particularly when poor health was the precipitant for retirement. Some representative comments made in the context of discussions of retirement and increases in negative emotion follow:

> I think that retirement is the beginning of the end . . . the last stage.
>
> You're supposed to be, you know, enjoy yourself. How can you enjoy yourself when you're in a doctor's office half your life?
>
> So many of my peers, I've found, they're just sitting around waiting to die [following retirement], and that's the tragic part.
>
> Most people aren't prepared for retirement.

One Korean Conflict veteran who had a particularly difficult transition during his forced retirement stated,

> When I had to go out, I went out on their terms and not on my terms. And I got suicidal, because *they* said, "You can't work," *I* didn't say, "I don't wanna work."

Another normative late-life phenomenon discussed by the focus group participants was the increasing number and frequency of deaths in their cohorts. Many veterans remarked that as more and more members of their cohorts, particularly fellow soldiers, begin to pass away, they find themselves thinking more about their time in combat. As one World War II veteran commented when speaking of an increase in troubling memories and feelings,

> You don't mean to think about it but it crops up. When you look at the obit you see a name, you might have gone to school with them, you might have been in the Navy with him or in the Army or in the Marine Corps. It starts your brain thinking. There are a lot of things that happen now that make you think of the past.

Another World War II veteran noted,

> You look in the newspaper and see all the flags [indicating the death of a war veteran] . . . boy, that's something, huh? . . . We lose at least two or three a month from our VFW. . . . I know a lot of people down there and you don't see them coming around no more.

A female veteran commented,

> My husband and I belong to the American Legion. . . . I'll tell you, we have a funeral ceremony about every other week.

Another World War II veteran described pleasant memories of his time in the service:

> I miss the camaraderie of the fellows that I was with. I still send out Christmas cards. And the numbers go down and down and down. But those memories are very good, the good times in that company. I really miss it. In my company, there's only five of us left.

Research Question 6

> If they observe LOSS in themselves or others, does their commentary reveal attributions of responsibility, perceptions of control, self-efficacy, or strategies that seem to reduce symptoms?

Many of the comments from focus group members implicated intrapersonal factors and qualities that might contribute to late-life resilience and might prevent, or at least lessen, distressing LOSS-related thoughts and feelings. One of the most prominent of these factors was the ability of some veterans to gain a sense of self-efficacy from their difficult wartime experiences. As one World War II veteran remarked,

> Although the experience was sort of a horror and you wouldn't want to go through it again, but we still cherish the difficulties and the fact that you survived. That's the way I feel.

Another very important, and related, factor that emerged from the focus group discussions was the ability to make meaning and to recognize the good that can spring from adversity. Aldwin et al. (1994) found that the tendency to perceive benefits from stressful military service decreased the relationship between past combat exposure and PTSD in later life. Comments from veter-

ans in our sample also suggested that positive appraisals of military service might provide somewhat of a buffer against the acknowledged deleterious effects. A veteran who was experiencing some late-onset combat-related memories but felt that he was managing them commented,

> For me, it [wartime military service] helped make me a better person. I began to have more understanding and compassion, more wanting to help people. I became a much better person afterwards, even though it took me years to bring back and relive the war.

Another veteran, acknowledging the pain he had experienced during the war, expressed that nonetheless he valued having been there:

> There were a lot of terrible memories. . . . As I look back on it, I think it was one of the—I don't mean to make it glory—but it's one of the greatest experiences of my life. And I probably would do it again and I don't regret going, even with what took place, which was pretty bad.

A conversation that transpired in the women's focus group also reflected the importance of having been able to find meaning and purpose, and the value of having drawn resilience, resourcefulness, and a sense of mastery from difficult wartime experiences:

> *Veteran 1:* If you have to think about one thing that you got out of all this [combat-related experiences], it's the ability to tackle any job. When anything confronts you, if you look at it, you'll live through it.
> *Veteran 2:* You become resourceful.
> *Veteran 3:* You will be able to cope.
> *Veteran 4:* Yes, because you had no choice. You had no choice and you had to find the way to cope.

Many of our focus group participants emphasized the importance of keeping busy and remaining engaged with the world throughout old age. The veterans who stressed the importance of continued engagement tended to be the ones who were experiencing less negative affect and distressing memories, suggesting that engagement may be a potential protective factor. Several veterans linked the importance of staying busy and engaged to the potential pitfalls of retirement in a cautionary manner:

> I looked forward to retirement as a chance [to pursue hobbies] full-time and since then . . . I'm having a ball. An absolute ball. [But] I recommend very highly practicing for it.

> You can't sit around—that's out of the question . . . if you sit at home, you're defeated, as far as I'm concerned.
>
> If it isn't money, you have to have motivation or incentive to do something else [when you retire].

Several veterans voiced the importance of being able to find and enjoy the good even while acknowledging the bad. This ability to appreciate and enjoy what one still has in the face of the changes and challenges of aging (and the sometimes painful memories from past wartime military service) may be a personal characteristic that serves as a protective factor in the face of LOSS and in the face of other difficulty as well. As one veteran phrased it,

> I think all of us have it in the back of our minds, but as long as we can get out of bed and enjoy the day and enjoy the company of our wives and our family, it's good . . . but it'll always be in the back of our minds like so many of our buddies.

Another veteran joked,

> Most of the time we have to read the obits every morning to see if we're in there . . . and if your name isn't in there, then you get up, get dressed, and go out.

Finally, analysis of the focus group data yielded indications of some possible intrapersonal risk factors, such as an external attribution of control and a lack of self-efficacy:

> You can't do anything about your health.
>
> The body falls apart.
>
> When you retire, your health goes.
>
> I know I'm not going to get any better.
>
> [After retirement] I had to just sit there . . . look out the window. I just didn't know what to do with myself.
>
> If you fear and believe that you're finished, then you're finished. You're going to just decay and you're going to end up in a nursing home. I experienced that. There was a mental attitude, [similar to that in] Vietnam.

In contrast, comments from two veterans who appeared to be doing well suggest a more internal locus of control and higher self-efficacy:

> There's no way I'm going to turn my life over and say, "Oh, I'm old, I'm ready to die."

> What I'm trying to say is that mortality is inevitable . . . [but] if God gives me 1 year, or 6 years, or 12 years or 14 years, what am I going to do with the time that He has given me?

Conclusions

The goal of this pilot study was to provide preliminary evidence for, and explore potential antecedents and correlates of, LOSS in aging combat veterans. LOSS was hypothesized to be a phenomenon among older veterans who (a) were exposed to highly stressful war-zone events in their early adult years; (b) have functioned successfully, with no long-term histories of chronic stress-related disorders; but (c) begin to register combat-related thoughts, feelings, reminiscences, memories, or symptoms commensurate with the changes and challenges of the aging process (e.g., retirement, the loss of a spouse, physical illness), often 30, 40, or 50 years after their combat experiences. Although our study was small and should be considered exploratory, we feel that our research team was able to provide preliminary evidence for the phenomenon of LOSS by conducting focus groups with World War II, Korean Conflict, and Vietnam War combat veterans. Through the comments of veterans, we were able to identify potential features of the LOSS phenomenon and potential contextual factors of LOSS. Additionally, the focus group data yielded valuable clues as to some of the possible antecedents and correlates of LOSS. The nature of our inquiry made it more difficult to identify background characteristics that might render one more vulnerable or more resilient to LOSS. In the future, our planned linkages to longitudinal data sets on veterans (i.e., the R.E. Mitchell Center for Prisoner of War Studies, the Normative Aging Study, and the Veterans' Health Study) may yield more information on life course factors that may contribute to the emergence of or absence of LOSS in aging combat veterans.

Why is it important to study the phenomenon of late-onset stress in older combat veterans? As mentioned earlier, the veteran population in our country is aging rapidly, and a population explosion of older Vietnam veterans is imminent. Given that late-onset distress has already been documented in some aging veterans, it seems important that we learn more about this phenomenon so that we ultimately can develop appropriate interventions and approaches to assist those veterans struggling with this phenomenon in navigating the vicissitudes of the aging process. In particular, effective identification of LOSS has the potential to help avoid misdiagnosis and ineffective treatment approaches in those aging combat veterans who may be exhibiting distress, which could in turn help prevent needless functional decline.

Knowledge of LOSS among practitioners who work with older veterans may lead to more accuracy in diagnosis and more appropriate courses of treatment. Greater knowledge among practitioners could also equip them to assist veterans who are not experiencing distress per se but may have questions about their recent increase in reminiscences or preoccupation. (The normalization of feelings and experiences by health practitioners can go a long way toward alleviating concern on the part of patients.)

Our research group has already successfully used the data generated by our focus groups to develop a LOSS instrument, and we have piloted it on a large, diverse sample of aging combat veterans. The measure has proved to be highly reliable, and there is encouraging evidence for its validity (King et al. forthcoming). We are in the process of disseminating the LOSS measure to colleagues for further use and validation. At this time, it is unclear whether a measure such as ours will have utility (or indeed whether its use should even be encouraged) in a practice setting; however, it is our hope that the measure will prove useful in guiding future inquiries into the late-life experiences of combat veterans.

As mentioned earlier in this article, a fundamental issue our research team has confronted during our discussions of the focus group data and during our subsequent LOSS instrument development and piloting (King et al. forthcoming) is the relationship between LOSS and PTSD. How is LOSS different from PTSD? Is it simply delayed PTSD? Or is it a distinct phenomenon altogether? Although the relationship between LOSS and PTSD warrants further discussion and investigation, we believe that LOSS represents a unique phenomenon that emerges within the context of normative late-life events. As discussed earlier, delayed-onset PTSD has been documented in some veterans; however, delayed PTSD as currently conceptualized is not linked to normative aging factors but rather is linked directly to traumatic events, no matter how distal. Indeed, in our hypothesized model of LOSS, there is no direct connection between early combat trauma and LOSS; the development of LOSS is filtered through late-life events and intrapersonal risk and resilience factors.

Of course, one would expect that a veteran with delayed-onset PTSD would also endorse some features of LOSS. We believe, however, that LOSS represents a broader construct than PTSD and encompasses a continuum of combat trauma-related phenomenology that specifically manifest within the context of normative late-life stressors. Additionally, the LOSS construct does not require that veterans with LOSS experience "clinically significant distress or impairment . . . in functioning," in contrast to PTSD (American Psychiatric Association 1994:429). Indeed, many of the veterans in our focus

groups did not indicate that they were disturbed by their late-onset memories and musings. As mentioned earlier, one way of conceptualizing LOSS is as one aspect of normative aging for combat veterans.

Another key differentiation between LOSS and PTSD is the central role that reminiscence appears to play in the emergence and phenomenology of LOSS. The data from our focus groups suggest that, in stark contrast to PTSD, reminiscence is far more prominent than either avoidance or reexperiencing symptoms in LOSS. In fact, we did not find any evidence in the veterans' comments and observations to suggest that avoidance was a feature of LOSS at all. Consistent with developmental theories that highlight the role of life review and reminiscence in normative aging (e.g., Erikson 1968), veterans in all of our focus groups indicated that they found themselves reminiscing more frequently now than they had done when they were younger, and this reminiscing typically appeared to be welcomed and even sought out. And as reminiscence can be considered a normative developmental process, this again places the features of LOSS in contrast with the (nonnormative, distressing) symptoms associated with PTSD.

One of the most important aspects of the research program described in this paper is that it begins not only to identify some of the potential links between early life traumatic war experiences and late life vulnerabilities but also to elucidate various factors that may contribute to resilience in old age for combat veterans. Future investigations involving the LOSS measure designed from our focus group data (King et al. forthcoming) may help further our understanding of late-onset stress in aging combat veterans. Further inquiry is also necessary to determine the degree to which our preliminary findings generalize to other populations of trauma survivors. It may be that the LOSS phenomenon proves unique to aging combat veterans; the collective nature of their traumatic wartime events and the cultural significance of their sacrifices—particularly in the case of World War II veterans, revered and dubbed "the greatest generation" by Tom Brokaw and American popular culture alike—may be a decisive factor in the phenomenology of LOSS. We may find that Vietnam veterans exhibit a very different type of late-life stress because of the particulars of their war and the historical context of their time in the service. And we may discover that late-onset stress looks completely different in survivors of noncombat trauma, for example, survivors of more "solitary," less shared, collective traumas. The LOSS construct is now being extended by one of us (E.H.D.) to another trauma population—older women with early-life histories of sexual trauma—with the hope that it may reveal some of the unique struggles, and also some of the striking strengths and resiliencies, that have been documented in this population.

Note

1. We believe that we were largely successful in screening out veterans with serious psychopathology. However, in one case, a veteran disclosed his diagnosis of PTSD and his history of long-term psychiatric treatment during focus group discussion. In contrast, during another focus group discussion, a veteran with no history of mental health problems or treatment described significant symptoms of depression and combat-related trauma following the recent death of his wife; the focus group moderator checked in with him following the group, assessed him for suicidality (he had none), and provided him with mental health referrals (it is unknown whether the veteran sought professional help). In accordance with our inclusion and exclusion criteria, we discarded the data from the former veteran and kept the data from the latter veteran.

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